STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	010739	A. BUILDING: _____ B. WING _____	C 07/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00203471 and IN00204016. Complaint IN00203471- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00204016- Substantiated. No deficiencies related to the allegations are cited. Survey Date: July 11, 2016 Facility number: 010739 Provider number: 155764 AIM number: 200856890 Residential Census: 61 Sample: 8 Spring Mill Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00203471 and IN00204016. QR was completed by 99993 on 07/12/16.	R 000		